Mountain-Pacific
uality Health Foundation

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"The best quality health care is provided to every patient we serve, every time."

Montana Medicaid Prior Authorization Request Form for Use of

Suboxone® (buprenorphine/naloxone) or Subutex® (buprenorphine)

Coverage Restricted Exclusively for the Treatment of Opioid Addiction

Providers must submit their **Treatment Plan** before authorization will be considered.

At a minimum the **Treatment Plan** must include the following information:

- Documentation of assessment and screening for opioid dependence (DAST-10, DSM-IV)
- Documentation of opioid substance of abuse
- Documentation of proposed counseling schedule
- Documentation of proposed monitoring plan (urine drug screens, random pill counts, etc.)
- Copy of Controlled Substance/Treatment Contract which must include consequences for failure to comply

Patient's Name: _____ Date: _____

Patient I. D. Number: _____ D.O.B: _____

Physician's Name :_____

Physician's Phone # _____Physician's Fax Number: _____

Drug/Dose Request: _____ (mg) Daily Directions: _____ (i.e.: 1 QD)

Is patient pregnant or nursing?_____ If Yes, Due Date?_____

Signature of Physician: _____

DEA#: X-_____(Prescriber must have an X-DEA Number)

Please complete form, attach documentation and fax to:
Medicaid Drug Prior Authorization Unit
1-800-294-1350

Montana Medicaid
Suboxone®/Subutex® Authorization Limitations

Covered Condition – Treatment of Opioid Addiction

Subutex®: Approvals will be limited to 5 days to allow for induction in the absence of a pregnancy diagnosis. For pregnancy, Subutex® will be authorized only for the duration of pregnancy. Maximum dose limitations for Suboxone® will apply.

Suboxone®:

- Patient must be 16 years or older.
- **Initial approval** –Prior authorization will be granted for 6 months. Dosing will be limited to maximum buprenorphine 24 mg/day. Requests for >24 mg/day will require provider documentation.
- *Documentation of compliance with all counseling, drug screen, and office visits must be provided for continuation of therapy beyond initial 6 months.*
- **Subsequent approvals-** Prior authorization will be granted for additional 6 month intervals up to 18 months to allow for a total of 24 months of therapy. Dosing will be limited to maximum buprenorphine 16 mg/day.
- Requests for dose increases will require provider documentation.
- Concurrent opioids, tramadol, or carisoprodol will not be covered. If a patient is Prior Authorized for Suboxone®/Subutex® after meeting all criteria and subsequently discontinues the medication, all opioids, tramadol formulations, and carisoprodol will remain on not-covered status. These medications will require Prior Authorization for any future prescriptions. Approval may be granted short-term for an acute injury, hospitalization, or other appropriate diagnosis only after the case is reviewed with the treating physician and the physician prescribing Suboxone®/Subutex®.

- **Note: Approval may be cancelled at any time if patient fails to comply with Treatment Plan: failure to attend counseling sessions; missed or inappropriate results from drug screens; breaking controlled substance/treatment contract.**